Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2019	2019_593573_0001	001804-18, 013137-18, 014252-18, 017991-18, 027519-18, 030254-18, 033095-18	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

Almonte Country Haven
333 Country Street P.O. Box 250 ALMONTE ON K0A 1A0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 03, 04, 07, 08, 09, 10 and 14, 2019.

During this inspection the following Critical Incident (CI) Logs were inspected:

Log: 001804-18 regarding alleged resident to resident physical abuse incident.

Log: 017991-18 and 027519 -18 regarding alleged staff to resident emotional abuse and neglect.

Log(s): 013137-18, 014252-18, 030254-18 and 033095-18 related to fall incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector reviewed Critical Incident (CI) reports, residents health record (including assessments, care plans, progress notes and PSW Daily Care Flow sheet documentation), licensee's relevant policies, licensee's internal investigation report and staff training records. In addition, Inspector observed the provision of care and services to the residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and that where the condition and circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Related to Log: #33095-18, for resident #003

Critical Incident Report (CIR) submitted on a specified date in 2018, indicated that an incident that caused an injury to resident #003 for which the resident was taken to hospital and that resulted in a significant change in the resident's health status.

On January 07, 2019, Inspector #573 reviewed resident #003's health care record which indicated that resident #003 was at risk for falls. Further, a review of the resident's health care record shows that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for the identified fall incident.

Related to Log: #013137-18, for resident #004

CIR submitted on a specified in 2018, indicated that an incident that caused an injury to resident #004 for which the resident was taken to hospital and that resulted in a significant change in the resident's health status.

On January 08, 2019, Inspector #573 reviewed resident #004's health care record which indicated that resident #004 was at high risk for falls and had multiple fall incidents. Inspector #573 reviewed resident #004's progress notes that indicated resident #004 had another fall incident with injury on a specified month in 2018, for which the resident was transferred to hospital. Further, a review of the resident's health care record shows that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for the two identified fall incidents.

On January 09, 2019, Inspector #573 spoke with the DOC who stated to the inspector that when a resident has fallen, registered nursing staff must do a post fall assessment, and to complete a post fall assessment tool specifically designed for falls in the Medicare e -Assessment. Furthermore, the DOC stated to Inspector #573 that they were unable to find the completed post fall assessment tool for resident #003 and resident #004's identified fall incidents. (Log #33095-18 and #013137-18) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident has been assessed and that where the condition and circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out the planned care for the resident.

CIR submitted on a specified date, indicated that an incident that caused an injury to resident #004 for which the resident was taken to hospital and that resulted in a significant change in the resident's health status.

On a specified date and time, Inspector #573 observed resident #004 in the bed, the bed was kept at the lowest position and a fall prevention floor mat was in place. Same day at a specified hours, Inspector #573 observed resident #004 was sitting in a wheelchair at the unit's corridor.

On January 08, 2019, Inspector spoke with PSW #104, who stated that resident #004 was at high risk for falls. The PSW stated that when the resident is unsteady on the feet, wheelchair used for resident #004's mobility. Further, the PSW stated that the floor mat and wheel chair is used as the fall prevention interventions.

On January 08, 2019, Inspector #573 reviewed resident #004's health care records which indicated that resident #004 was at high risk for falls and had multiple fall incidents. Inspector #573 reviewed resident #004 written plan of care in place, upon review, Inspector observed that resident's written plan of care does not include the use of wheelchair nor the floor mat for resident #004.

On January 08, 2019, Inspector spoke with RN #105, who stated that they were not aware of the use of the fall prevention floor mat for resident #004. Further, the RN confirmed with the inspector that resident #004's written plan of care in place does not include the use of the floor mat and the wheelchair for the resident.

Resident #004's written plan of care does not set out the planned care for the resident, as it relates to the resident's fall prevention intervention and mobility needs. (Log #013137-18) [s. 6. (1) (a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the resident's abuse or neglect investigation were reported to the Director.

On a specified date, CIR was submitted to the Director for an alleged staff to resident #007 emotional abuse.

The DOC indicated during an interview on January 10, 2019, with Inspector #573 that an investigation related to the allegation of emotional abuse of resident #007 was initiated immediately.The DOC stated that the internal investigation confirmed that staff to resident emotional abuse occurred and disciplinary action were taken against the staff member. Furthermore, the DOC stated to Inspector #573 that the results of the abuse investigation was not reported to the Director. (Log #017991-18) [s. 23. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O. Reg. 79/10, section 5, "Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

A CIR was submitted to the Director on a specified date, reporting an alleged staff to resident's neglect.

On January 10, 2019, Inspector #573 reviewed the home's internal investigation records, which indicated that on a specified date and time, PSW #104 reported to the in charge RN #108 regarding concerns over PSW #107, who denied care to resident #008.

During an interview with Inspector #573 on January 10, 2019, RN #108 stated that on a specified date and time, PSW #104 reported concerns over PSW #107's conduct and interactions with resident #008. Further, RN #108 confirmed with the inspector that they did not report the incident at that time to the Director nor the on call manager.

On January 14, 2019, Inspector #573 spoke with the Administrator, who indicated that two days after the incident, PSW #104 reported allegation of PSW #107 to resident #008's neglect of care that occurred on a specified date and time. The Administrator stated to the inspector that an investigation was initiated immediately and PSW #107 was placed on investigation leave. The Administrator stated that the internal investigation confirmed that staff to resident #008 neglect occurred and disciplinary action were taken against PSW #107. Further, the Administrator indicated that it was the responsibility of RN #108 to report the allegations of resident's neglect to the designated manager on call but because the designated manager on call was not notified, the incident had not been reported until the CIR was submitted which was two days after the incident. (Log #027519-18) [s. 24. (1)]

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Issued on this 21st day of January, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.